Auditing Injections and Infusions

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Presentation Faculty

Duane C. Abbey, Ph.D., CFP – Dr. Abbey is a healthcare consultant and educator with over 20 years of experience. He has worked with hospitals, clinics, physicians in various specialties, home health agencies and other health care providers.

His primary work is with optimizing reimbursement under various Prospective Payment Systems. He also works extensively with various compliance issues and performs chargemaster reviews along with coding and billing audits.

Dr. Abbey is the President of Abbey & Abbey, Consultants, Inc. A wide range of consulting services is provided across the country including charge master reviews, APC compliance reviews, in-service training, physician training, and coding and billing reviews.

Dr. Abbey is the author of fourteen books on health care, including:

• “Non-Physician Providers: Guide to Coding, Billing, and Reimbursement”
• “Emergency Department: Coding, Billing and Reimbursement”, and
• “Chargemasters: Strategies to Ensure Accurate Reimbursement and Compliance”.

Recent books include: “Compliance for Coding, Billing & Reimbursement A Systematic Approach to Developing a Comprehensive Program”, “Introduction to Healthcare Payment Systems”, “Fee Schedule Payment Systems” and “Prospective Payment Systems” from Taylor and Francis. He has just finished the fourth book in the Healthcare Payment System Series; “Cost-Based, Charge-Based and Contractual Payment Systems”.

Auditing Injections & Infusions

Introduction

- Auditing Injections, Infusions and Drug Administration
  - Injections and Infusions Represent a Complex Coding Area
  - Auditors Must Establish Coding and Billing Guidelines That Can Be Used in Reviewing Cases
    - Note: There can be some variability between third-party payers relative to claims filing and adjudication. For instance, see the CMS NCCI Coding Policy Manual.
  - Auditors Must Review the Coding and Billing Processes
    - For different areas, the coding and charge capture process may be quite different. See chemotherapy in an Infusion Center.
  - Auditors Must Also Review Documentation and Associated Documentation Systems
    - See Electronic Health Records (EHR) and other documentation systems.
    - Again there may be variation between service areas on how documentation is developed.
  - Drug and Drug Reconciliation May Be A Part of Auditing Injections and Infusions
    - Often these studies are performed separately and take a great deal of time and effort.
For most hospitals, outpatient coding commenced in conjunction with the implementation of APCs by the Medicare Program on August 1, 2000.
- Some hospitals were already under various APG-type payment systems.

Under APGs, injections and infusions were generally bundled into an associated service. See recent CMS move to increase packaging. Will this eventually lead to packaging injections/infusions??

In a very surprising move, CMS decided to pay separately for injections, infusions and chemotherapy administration.
- However, hospitals were not correctly coding and billing for these services prior to APC implementation.
- Incorrect coding and charge data then led to skewed payments for injections, infusions and chemotherapy.
- CMS has constantly made changes to the APC payment structure and has modified the Q-Codes that were used on a bundled, ‘session’ basis.

In 2005, the AMA announced and pre-published a whole new structure and coding logic for injections, infusions and chemotherapy.

The new codes and coding structure were placed in the AMA’s CPT Manual for 2006.
- For the APCs, CMS adopted only a portion of the new codes. CAHs did start using all the new CPT codes starting in CY2006.
  - CMS still wanted to use the ‘per-session’ coding and payment logic.
  - A whole series of new Level II HCPCS C-Codes were developed.
    - CMS indicated that these codes were developed for the ‘benefit’ of hospitals.

In the proposed changes to APCs for CY2007, CMS indicated that they planned to continue the C-Codes as a benefit to hospitals.
- Hospitals responded by requesting that CMS implement the new CPT codes immediately. CMS adopted the new codes for CY2007 with one C-Code retained.
In a surprising move, the AMA decided to renumber the injection and infusion codes for CY2009. The chemotherapy codes did not change as such. The placement of the renumbered injections and infusion is more logical.

While the actual code numbers are being translated, careful study is needed to determine if the language and instructions associated with the codes has been substantively changed.

As much as possible, any changes in the CPT Manual instructions will be given during this teleconference.

For 2011 there was only one change – New Code 96446 for Chemotherapy administration into peritoneal cavity via indwelling port or catheter.

For 2012 and on into 2013 there were extensive additions and/or revisions to the coding guidelines as found in CPT. Note that CMS does not necessarily follow the guidelines found in CPT.

Need to follow CMS guidance on the use and non-use of injection and infusion codes.
- See NCCI Edits
- See NCCI Coding Policy Guidance

Auditing Concerns

Injection and Infusion Problem Areas
- Proper Use of the Coding Logic Provided in CPT
- Documentation – Start and Stop Times
- Chargemaster Updating
  - Revenue code decisions and Cost Report interface
- Charge Capture and Possible Static Coding Through the Chargemaster
  - Note: Is it enough for clinical staff to simply document all the drugs and administration of drugs and to then –
    - Allow professional coding staff to code and enter charges?
- Use and/or Misuse of the “-59” Modifier
- Observation Services
  - Is there a difference between regular observation and post-outpatient surgery observation relative to injections/infusions?
  - How to handle the active monitoring issue for bed-side injections and infusions.
- Surgery
  - Pre-, Intra- and Post-Operative Injections and Infusions
    - See NCCI Coding Policy Guidelines
Auditing Injections & Infusions
Objectives

- To review the CPT coding logic and directives for injections, infusion therapy and chemotherapy.
- To discuss the documentation that is need to justify drug reporting and the administration of drugs, both clinically and for proper reimbursement.
- To identify key policy and procedure elements in the use of the injection and infusion CPT codes.
- To discuss the difficulties for injections and infusions in observation.
- To appreciate different approaches for charge capture and associated coding and billing through charge capture.
- To understand the potential reimbursement for injections and infusion therapy under APCs.
- To appreciate the value of auditing activities for compliance and process change.
- To explore related issues such as ‘integral-part’ and ‘not to be reported separately’ compliance guidance from CPT and CMS.
- To address injection and infusion coding guidance as found in the NCCI coding policies.

Review the logic that comprises the coding guidance provided in the CPT Manual,

- Proper coding/billing requires that the overall case be reviewed to determine correct code and charges.
- Determine how coding and billing occurs in different service areas,
- Check the chargemaster for the new codes, appropriate pricing, and charge capture,
- Review written policies and procedures for coding and billing injections including the use of modifiers when necessary,
- Identify and incorporate any special coding/billing considerations based upon specific guidance from given third-party payers,
- Check for training for coding and nursing staff,
  - Check for ‘coding sheets’ or ‘coding templates’.
- Review ongoing training and auditing for correct charge capture and subsequent coding and billing.
Auditing Injections & Infusions
The Injection/Infusion/Chemotherapy Codes

- Code Summary with APC Payments
  - Hydration -
    - 96360 (1st Hour) - $74.69
    - 96361 (Each Additional Hour) - $27.01
  - IV Therapy -
    - 96365 (1st Hour) - $146.24
    - 96366 (Each Additional Hour) - $27.01
    - 96367 (Additional Sequential) - $39.13
    - 96368 (Concurrent) - $ 0.00 – Status Indicator “N”
  - SQ Infusion -
    - 96369 (1st Hour) – $146.24
    - 96370 (Each Additional Hour) - $39.13
    - 96371 (Additional Set-up New Site(s)) - $39.13
  - Injection –
    - SQ/IM - 96372 - $39.13
  - IV Injection –
    - 96374 (Initial IV Push) – $39.13
    - 96375 (Sequential IV Push) - $39.13
    - 96376 (Each Additional IV Push) – SI=“N” – Packaged
  - Unlisted – 96379 - $27.01

Related Chemotherapy Administration Codes

- 96409 – IV Push, Single or Initial APC=0439-$146.24
- +96411 – IV Push, Each Additional APC=0438-$74.69
- 96413 – IV Infusion – 1 Hour, Sing or Initial APC=0440-$230.50
- +96415 – IV Infusion – Each Addn’l Hour APC=0437-$39.13
- 96416 – Prolonged Portable/Implantable Pump APC=0440-$230.50
- +96417 – IV Infusion – 1 Hour (Different Drug) APC=0438-$74.69

- CMS Retained – C8957 – Prolonged IV Infusion Requiring Pump
  - APC=0440-$230.50
Auditing Injections & Infusions
CPT Coding Guidelines & Logic

- The Logic for Coding/Billing Injections and Infusions, Along With The Codes, Has Morphed Over the Past Ten Years
  - Obviously, this has created much confusion!
    - Will the RACs (Recovery Audit Contractors) become involved??

  - “In order to determine which service should be reported as the initial service when there is more than one type of service, hierarchies have been created. These vary by whether the physician or other qualified health care professional or a facility is reporting. The order of selection for reporting is based upon the physician’s or other qualified healthcare professional’s knowledge of the clinical condition(s) and treatment(s). The hierarchy that facilities are to use is based upon a structural algorithm. When these codes are reported by the physician or other qualified health care professional, the “initial” code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur.” (Page 544, 2013 CPT Manual)

• This language is unchanged for CY2013.

Auditing Injections & Infusions
CPT Coding Guidelines & Logic

  - “When these codes are reported by the facility, the following instructions apply. The initial code should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services which are primary to therapeutic, prophylactic, and diagnostic services which are primary to hydration services.” (Page 518 2012 CPT)
  - “Infusions are primary to pushes, which are primary to injections. This hierarchy is to be followed by facilities and supersedes parenthetical instructions for add-on codes that suggest an add-on of a higher hierarchical position may be reported in conjunction with a base code of a lower position. (For example, the hierarchy would not permit reporting 96376 with 96360, as 96367 is a higher order code. IV push is primary to hydration.)” (Page 518 2012 CPT)
    - This language is unchanged for CY2013.
Auditing Injections & Infusions
CPT Coding Guidelines & Logic

- Embedded CPT Guidance ↔ Study Carefully, But?
  - 96360 – Hydration 1 Hour → Do not report if performed as a concurrent infusion service.
    - What does this mean?
  - +96361 – Hydration Each Additional Hour
    - Use 96361 in conjunction with 96360
    - Use 96361 to identify hydration if provided as a secondary or subsequent service after a different initial service
      - 96360, 96365, 96374, 96409, 96413
    - 96365-96379 series is for administration of substances/drugs.
  - Note the 15 minute rule to distinguish between 'IV Injection' and 'IV Therapy'
  - Note the 30 minute rule for each additional hour to be counted within the sequence of codes supporting the each additional hour. (See the general “half-time unit” rule under Medicare.)

Auditing Injections & Infusions
CPT Coding Guidelines & Logic

- Hydration Guidelines Starting CY2012
  - “Some chemotherapeutic agents and other therapeutic agents require pre- and/or post-hydration to be given in order to avoid specific toxicities. A minimum time duration of 31 minutes of hydration infusion is required to report the service. However, the hydration codes 96360 and 96361 are not used when the purpose of the intravenous fluid is to “keep open” an IV line prior or subsequent to a therapeutic infusion, or as a free-flowing IV during chemotherapy or other therapeutic infusion.” (Page 519 2012 CPT)

- Hydration Guidelines Starting CY2013
  - “Typically such infusions require little special handling to prepare or dispose of, and staff that administer these do not typically require advanced practice training. After initial set-up, infusion typically entails little patient risk and thus little monitoring. These codes are not intended to be reported by the physician or other qualified health care professional in the facility setting.” (Page 545 2013 CPT)
Auditing Injections & Infusions
CPT Coding Guidelines & Logic

- Embedded CPT Guidance ← Study Carefully, But?
  - Do not report 96365-96379 for codes in which these services are an inherent part. (Contrast materials for interventional radiology, etc.)
  - 96365 – IV Infusion Up To 1 Hour
  - 96366 – IV Infusion Each Additional Hour
    - Add-on Code
    - Generally used with 96365 (IV Therapy 1st Hour) and/or 96367 (Additional Sequential Infusion 1st Hour)
      - This is interesting!
  - 96367 – IV Infusion Additional Sequential 1st Hour
    - Add-on Code
    - Report only once per sequential infusion of the same infusate mix
    - Generally used with 96365, 96374, 96409, 96413 if secondary or subsequent service

Auditing Injections & Infusions
CPT Coding Guidelines & Logic

- Embedded CPT Guidance ← Study Carefully, But?
  - 96368 – IV infusion Concurrent
    - Add-on Code
    - Report only once per encounter
    - Use with 90761->96365, 90766->96366, 96413, 96415, 96416, 96422, 96423
  - 96369, +96370, +96371
    - New sequence for CY2008 – Appears to stand alone as with SQ/IM and IV pushes.
  - 96372 – SQ/IM Injection
    - Our old friend with a new code
    - New guidance – “(Do not report 96372 for injections given without direct physician supervision. To report, use 99211. Hospitals may report 96372 when the physician is not present.)”
      - What does this mean?
        - For hospitals? Provider-based clinics?
        - For physicians? Physician (freestanding) clinics?
Auditing Injections & Infusions
CPT Coding Guidelines & Logic

- Embedded CPT Guidance
  - Study Carefully, But?
    - 96373 – Intra-Arterial Injection
      - Basically the old code with a new number.
    - 96374 – IV Push, Single or Initial Substance Drug
      - The wording has been revised to fit the new logic.
      - There is no parenthetical guidance.
    - +96375 – IV Push, Each Additional Sequential Push of New Substance/Drug
      - Add-on Code
      - Use with 96365, 96374, 96409, 96413
      - Use to identify IV push of a new substance/drug if provided as a secondary or subsequent service after a different initial service is provided.
    - +96376 – IV Push, Each Additional Push of Same Substance/Drug
      - However, this is a 30 minute rule!
    - 96379 – Unlisted Injection/Infusion
      - Avoid Using!

Auditing Injections & Infusions
Coding Logic

- CPT Guidelines Seem Reasonably Straightforward
  - Well, until you try to apply to real life situations!
  - Basic Idea - Physicians
    - Identify the “initial” service. Other services in this area will be secondary.
      - “When these codes are reported by the physician, the “initial” code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur.”
    - However, in order to identify the initial service, the ‘encounter’ will have to be completed.
      - For cases like observation services, this could be tricky because the coding cannot be completed until after the encounter is completed.
        - Or is the physician ‘encounter’ different from the hospital ‘encounter’?
CPT Guidelines Seem Reasonably Straightforward

- Basic Idea – Hospitals (Facilities)
  - Use a hierarchical approach in selecting initial and subsequent.
    - "When these codes are reported by the facility, the following instructions apply. The initial code should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services which are primary to hydration services. Infusions are primary to pushes, which are primary to injections."

- The big question is who will be doing the coding?
  - Professional Coding Staff?
  - Nursing Staff in Service Areas?
  - Both?

Next big question is who is going to make the decision as to which service was the "initial" or "primary" service using the hierarchy?

- When and by what mechanism will this decision be made?
- Will the process be different depending upon the service area?
- How will the charging process enter into the overall way in which claims are generated for these services?
- Are there any concerns about chargemaster setup and organization?
- Should there be written policies and procedures? Templates?

Ancillary Concerns Not Addressed By CPT Codes/Guidelines

- “Integral Part” – Injections/Infusions – Pre- and Post-Surgery
  - See Increased Packaging – Intra-Operative for APCs starting in CY2008

- IV Solutions – Not Separately Reportable - Billable
Case Study #1 – Elderly patient present to the ED and is diagnosed with dehydration. Patient is placed on IV for hydration. Hydration provided for six hours. Patient is discharged home.

Case Study #2 – Patient presents to ED. An IV is started KVO. One IM/SQ injection is provided along with one IV injection. After three hours the patient is discharged home.

Case Study #3 – An elderly patient presents in the morning through the ED with dehydration and general weakness. The attending physician decides to admit. An IV is started for hydration. The patient is taken to a medical/surgical bed. The patient continues to receive hydration for five hours. An IM/SQ antibiotic injection is given. The patient is discharged in the afternoon. Utilization Review intervenes just before discharge and changes the case to Observation with Condition Code 44.

Case Study #4 - A patient is encountered in an outpatient area for one of a series of IVIGs (Immune Globulin). 50 grams of IG is provided by IV infusion over a period of four hours.
Auditing Injections & Infusions
Case Studies

- Case Study #5 - A patient presents to the ED. An IV is started KVO for possible drug administration. The IV is maintained for three hours during which an IV injection is provided and infusion therapy of a drug is started after half an hour and continued until the end of the third hour. Also, another drug is piggy-backed and provided as an additional infusion therapy for the second of the three hour encounter. The patient is discharged home.

- Case Study #6 - A patient arrives at the Apex Medical Center’s ED after a 45 minute trip. An IV was started before the ambulance left and hydration was provided during the trip. During the next two hours, the IV is continued with two IV injections and one bolus of medication are provided. The patient is admitted to observation over night. While the IV is kept in place, no further medications are provided and the patient is discharged the next morning.

- Case Study #7 – A patient presents to the ED at 10:00 p.m. An IV site is established. The ER physician order hydration for one hour. A slow IV push (5 minutes) of Drug A is provided at 11:30 p.m. At 11:45 p.m. an IV bolus of an antibiotic (Drug B) is started and is provided for two hours. However, at 12:30 a.m. the patient is moved to observation. At 1:30 a.m. a slow push (5 minutes) of Drug A is provided. At 3:30 a.m. another bolus of Drug B is provided, IV, for a period of two hours. The patient is discharged at 9:00 a.m. just after breakfast.
Case Study #8 - A patient presents to the ED with complaints of mild chest pain. The chest pain protocol is followed. An IV is started KVO. The patient is scheduled for a cardiac catheterization for the next morning. Due to kidney concerns the physician orders hydration overnight to reduce toxicity of the LOCMs (Low Osmolar Contrast Media). Hydration is provided over an eight hour period. During the observation stay, two subcutaneous injections are provided along with an IV bolus of another drug infused over a ten minute time period. There is also a piggy-back infusion over a three hour time period.

Case Study #9 – A patient is encountered in the ED. An IV is started KVO. The physician determines the patient is dehydrated. The attending physician arrives and orders a second IV site be started for administration of antibiotics and pain medications. The patient is admitted to observation. The patient is hydrated for a total of 9 hours. An antibiotic is provided through IV infusion over a period of two hours. Three different IV injections of morphine are provided to achieve the desired titration level. The patient is discharged the next morning.
Case Study #10 – An elderly patient presents to the ED in the late afternoon with chest pains. The chest pain protocol is followed. An IV is started KVO. A mild analgesic is provided IV over a period of three hours. The patient is admitted to observation and is scheduled to have coronary catheterization services. Prior to the procedure the patient is given an prophylactic antibiotic injection (assume IM/SQ). Fentanyl and Versed are provided IV for conscious sedation. Therapeutic coronary catheterization services involve a stent placement. (Drug-Eluting, of course!) The patient is discharged in the afternoon.

Case Study #11 -

- Day 1 - A patient present for a schedule IVIG injection. Nursing assessment indicates patient is sick. Told to return tomorrow.
- Day 2 – Patient receives a Benadryl 50 mg. IV Injection at 10:00 a.m. At 10:45 a.m. IVIG is started with 100 grams of IG. Infusion is stopped at 3:00 p.m.
- Day 3 – Patient presents and is infused with 50 grams of IG. The infusion starts at 12:30 p.m. and is discontinued at 4:10 p.m.
Case Study #12 – An elderly patient presents for a blood transfusion of two units of packed red blood cells. An IV is started and the patient is given an antibiotic IV injection. The first unit of blood is provided over a two hour period. As per physician orders, the patient is hydrated for two hours after which the second blood unit is administered. The patient is observed for two hour and then released to go home.

Case Study #13 – A patient presents to the ED. The physician orders IV hydration ‘wide-open’ for ten minutes. Presuming this is the only infusion/injection, how should this be coded?

Case Study #14 – Hydration with IV Infusion - A patient presents to the ED and is diagnosed with dehydration. Hydration is provided over a four hour period. During the third hour of hydration a mild antibiotic is provided on a prophylactic basis. The patient is discharged home at the end of the hydration. Assume that the record indicates that hydration is the primary service and that the one hour of infusion is secondary.
Case Study #15 – During an ED encounter, the physician orders (specifically) the following morphine IV injections –
- 11:30 p.m. – 15 mg
- 12:10 p.m. – 10 mg
- 12:40 p.m. – 5 mg

Assume the same basic facts, but assume the same sequence of injections by ED nursing staff to obtain an appropriate titration level.

Case Study #16 – Apex Medical Center – Infusion Center
- A patient presents to the infusion center for chemotherapy services
  - An IV is started
  - The patient is hydrated for one hour
  - The patient is given an antibiotic IV injection
  - IV infusion chemotherapy is administered for four hours
  - After the chemotherapy administration, an antiemetic is provided intravenously for one hour
- A patient presents to the infusion center for a blood transfusion
  - An IV is started
  - Benadryl is provided through an IV push
  - One unit of blood is transfused
  - Patient is hydrated with Lasix infusion for one hour
  - Second unit of blood is transfused
Auditing Injections & Infusions

Hierarchy For Coding

- If there are two or more primary services that can equally well be considered primary, then which one of the services is to be coded as primary?
- Today, CPT gives us general hierarchy of coding based upon the concept of an ‘encounter’?
  - Can the encounter be different for physicians versus the hospital?
  - Chemotherapy → Therapeutic/Prophylactic/Diagnostic → Hydration
  - Infusions → Pushes
- When does an infusion of a substance become chemotherapy?
- What is a push?
- What if we perform additional services relative to chemotherapy?
  - “The administration of medications (eg, antibiotics, steroidal agents, antiemetic, narcotics, analgesics) administered independently or sequentially as supportive management of chemotherapy administration, should be separately reported using 96360, 96361, 96365, 96379 as appropriate.” (Page 519 2012 CPT)

Auditing Injections & Infusions

Coding and Charging Flow

- Injection/Infusion/Chemotherapy Goal
  - Of course, we will assume that the hospital wishes to provide appropriate high quality healthcare relative to injections and infusion therapy.
  - To capture all appropriate charges and associated codes for injections and infusion therapy across all outpatient departments and service areas. Ultimately to generate good, clean, complete and accurate claims.
- For A Given Service Area, What Is The Best Way To Capture and Properly Code For These Services?
  - Example – Apex Medical Center ED
    - Physicians Order – Nurses Document Services
    - Dedicated ED coding staff reviews all clinical documentation
      - Codes the Services and Enters the Charges
  - Example – AMC Infusion Center
    - Chemotherapy Services
    - Other Infusion/Injection Services
Auditing Injections & Infusions Coding and Charging Flow

- Fundamental Question
  - Static Coding Through Chargemaster
    - versus
  - Dynamic Coding By Professional Coding Staff
- Special Issues
  - Judging what service is ‘primary’ or ‘initial’ using the hierarchy
  - Using ‘-59’ modifier when needed
- Hospitals will probably use multiple approaches based upon the specific coding/billing flow for a given service area.
  - Emergency Department
  - Medical/Surgical Floors (Observation)
  - Pre- and Post-Surgery Areas
  - Outpatient Service Areas
  - Provider-Based Clinics

Auditing Injections & Infusions Coding and Charging Flow

- Chargemaster Considerations
  - Coding – Static versus Dynamic
  - Structuring Charges
  - Special Third-Party Payer Requirements
  - Charge Sheets
  - Computer Charge Entry ← Build In Logic?
  - Pharmacy Categorization Issues → RC=0636 vs. RC=0250
Auditing Injections & Infusions
Policy and Procedure Issues

- There is a long list of P&P issues surrounding Hydration, Injections and Infusion Therapy
  - Auditors should check for written policies and procedures along with any training materials. Are the P&Ps in place, being followed, used in training, up-to-date, etc.?
    - Medical Necessity
    - Written Order
    - Drugs Charged Separately
    - IV Solution Charging
    - Start/Stop Times
    - 15-Minute Rule – IV Injection vs. IV Infusion Therapy
    - Half-Time Unit Rule ← Separate General P&P Hospital Wide
    - 1st Hour + Each Additional Hour Logic
    - KVO – Keep Vein Open Circumstances
    - Multiple Drugs
      - Injections – Mixing of Drugs (Versus Compounding)
      - IV Therapy – Concurrent Concept

Auditing Injections & Infusions
Policy and Procedure Issues

- There is a long list of P&P issues surrounding Hydration, Injections, Infusions and Chemotherapy
  - Multiple Sites
  - Vein Failure
  - Separate Encounters
  - Discontinue/Re-Establish
  - Routine, Integral Part ← See Hospital Wide General Policy
  - Multiple Injections, Same Drug
  - General Injection, Hydration, Infusion Therapy Logic
    - Primary/Initial vs. Secondary/Subsequent
    - Concurrent
    - Add-On Code Utilization
    - CPT Guidance
Auditing Injections & Infusions
Policy and Procedure Issues

➢ There is a long list of P&P issues surrounding Hydration, Injections and Infusion Therapy
  ▪ Standard Examples
    • Hydration Only
    • Infusion Only
    • SQ/IM Injections Only
    • Infusion + IV Injection
    • Infusion + Hydration
    • Chemotherapy + Infusion/Injections
    • Concurrent Infusions
    • Hydration + Infusion + SQ/IM Injections
    • Multiple Site Infusion Therapy
    • KVO With No Other Services
    • KVO with SQ/IM Injections
    • Injections & Infusions in Observation
    • Injections & Infusions During Surgery

Auditing Injections & Infusions
Policy and Procedure Issues

➢ There is a long list of P&P issues surrounding Hydration, Injections, Infusions and Chemotherapy
  ▪ Ancillary/Special Concerns
    • Immunizations and Vaccinations
    • Emergency Department Considerations
    • Observation Services Considerations
    • Recovery Services Considerations
    • Pre-Surgery Considerations
    • Interventional Radiology Considerations
    • Special Injection Situations → IVIG Series of Injections
    • Inpatient Changed to Outpatient Observation (Condition Code 44)
    • Blood Transfusions
    • Infusion Center Services
Auditing Injections & Infusions
Policy and Procedure Issues

- Injections/Infusions Involving Surgery Services
  - Injections and infusions of various types are given in conjunction with surgeries.
    - Pre-Operative vs. Intra-Operative vs. Post-Operative
    - Are these injections/infusions to be separately coded and billed?
  - For instance, pre-surgery antibiotic injections that are sometimes provided for certain patients.
    - Not Integral-Part
    - Thus, separately codeable and billable?

- FIs Have Generally Issued Guidance Prohibiting Coding/Billing
  - Payment is Packaged Into the Surgery Payment

- Transmittal 1445, February 8, 2008 – Section 230.2(B) – Billing for Infusions and Injection – New Sentence Added
  - “Hospitals should report all HCPCS codes that describe the drug administration services provided, regardless of whether or not those services are separately paid or their payment is packaged.”
    - Coding/Billing Issue vs. Payment/Adjudication Issue

Auditing Injections & Infusions
Policy and Procedure Issues

- NCCI Coding Policy Guidelines
  - “The global surgical package includes the administration of fluids and drugs during the operative procedure. CPT codes 96360-96376 should not be reported separately. Under OPPS, the administration of fluids and drugs during or for an operative procedure are included services and are not separately reportable (e.g., CPT codes 96360-96376).” (Chapter I- Pages 12-13, NCCI Policy Manual 1-1-2012 Revision)
    - This is found in the discussion of the physician global surgical package (GSP).
    - However, the NCCI coding policy is broken out for hospitals indicating that injections and infusions should not be separately reported.
      - Question: What does it mean to ‘report separately’?
      - How does this correlate with the guidance on the previous slide (i.e., report all HCPCS codes language)?
Auditing Injections & Infusions
Policy and Procedure Issues

➢ Observation and Injections/Infusions
  ▪ Generally, injections and infusions in observation are separately coded and billed on the basis of a single encounter that can span up to three dates-of-service. (Or longer is some cases!)
  ▪ CMS has issued guidance on the need to stop counting observation time (billed by the hour) when either diagnostic services or therapeutic services are provided during the observation stay.

  Two slightly different issues occur:

  • The patient is removed from the observation bed (and/or wherever services are being provided), the services are provided and then the patient is returned to the observation bed.
  • The services are provided at the bed-side. This can involved injections, infusions, minor procedures, etc.
    ○ Note the key phrase, ‘active monitoring’.
    ○ How does your policy define, ‘active monitoring’?

Q&A #9974 – Answer Continued

➢ The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services received by the patient. Whether active monitoring is a part of the drug administration service may depend on the type of drug administration service furnished, the specific drug administered, or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring. For concerns about specific clinical situations, hospitals should check with their Medicare contractors for further information.

➢ If the hospital determines that active monitoring is part of a drug administration service furnished to a particular patient and separately reported, then observation services should not be reported with HCPCS G0378 for that portion of the drug administration time when active monitoring is provided.
Auditing Injections & Infusions
Policy and Procedure Issues

- Observation Services – Post Outpatient Surgery
  - What if a patient undergoes outpatient surgery, is then taken to recovery, and, after the ‘normal’ recovery period has been exceeded, the physician admits the patient to observation services?
  - Now the observation services will not, per se, be paid. If there is any Status Indicator “T” service along with the observation, then the observation payment is bundled into the payment for the surgical services.
    - However, what about services such as injections and infusions that are provided during the observation stay?
    - Can these services be coded and billed (i.e., separately reported or separately billed)?

Auditing Injections & Infusions
Training and Auditing Considerations

- Depending on how coding and charge capture are taking place, auditors should carefully review training materials, methodologies and effectiveness.
  - Developing Training Materials
    - Educational Materials
    - Coding/Billing Templates
    - Coordination with Written P&Ps
  - Delivering Training
    - Self-Study
    - In-Person, Small Group
    - Videotape with Facilitator
    - Self-Paced Computer Training
      - Stand-Alone
      - Internet/Intranet
    - Help Desk
      - Informal versus Formal
  - Need for On-Going Training/Education
Auditing Injections & Infusions

Training and Auditing Considerations

➢ Auditing Activities

▪ Due to all the changes made for CY2007, more codes in CY2008, renumbering of codes in CY2009, on-going revisions to coding guidelines and the on-going concerns in previous years, the need for auditing in the hydration, infusion therapy and injection areas is significant.

▪ Auditing staff may look at many different aspects of this overall issue:
  • Clinical Documentation Correlated to Charge Capture/Coding
    o Number of Injections/Infusions Documented
    o Start and Stop Time and/or Documented Time
    o Correct Type of Injection/Infusion
    o Following Coding/Billing Logic
    o 15-Minute and Half-Time Unit Rule Observance
  • Correlation of Number of Drugs to Injections/Infusions
  • Claim Quality – Drugs, Revenue Codes, Codes
  • Charge Capture and Coding Flow Processes

Case Studies

➢ Case Study #17 - IV Injection - During her observations stay Sarah received a slow IV push. The push is provided over about 5 minutes. The nurse remains with Sarah for another 5 minutes to see if there is any reaction.

▪ Discuss how this type of situation should be handled in view of the recent update guidance concerning observation from CMS.

▪ What kind of a policy and procedure will you use in this area?
  • How will you know your policy and procedure is correct?

▪ What if the push involved the nurse for 30 minutes?
Case Study #18 – Samantha, the Chief Compliance Officer at the Apex Medical Center is reviewing the results of an extended probe audit of infusion therapy at the hospital. A total of 45 cases were reviewed. The results of the audit are generally good. The clinical documentation is complete in terms of the services provided. Also, the number of drugs charged correlates well with infusion therapy services. The only real problem is that nursing staff was very good about indicating the time that an infusion started, but in about half the cases the stop time was not documented. However, charges for all the services were being entered.

- Is this a compliance problem?
- What steps should Samantha take in this case.
  - Note: From 2012 CPT Manual, “When reporting codes for which infusion time is a factor, use the actual time over which the infusion is administered.” (Page 518 2012 CPT)

Case Study #19 – Pre-Operative Antibiotic Injection – For certain patients undergoing certain types of surgery, the surgeon may order that an antibiotic injection be provided just before the operation is commenced. Often, this injection is provided by the anesthesiologist while sometimes it is provided by surgical nursing staff.

- How should this be coded and billed?
- Does it make any difference if the anesthesiologist or the nurse provides the injection?
- Does this injection qualify as an integral part?
Case Study #20 – Vitamin Injection – Sarah has a standing order to receive a vitamin injection at the Acme Medical Clinic once a month. Typically, she presents and is seen by a nurse who does a brief assessment (interval history, height, weight, blood pressure, heart rate, respiration rate). If the nurse determines that the injection can be safely provided, the injection is provided.

- Discuss how to code and bill for this type of encounter under the following circumstances. For each case discuss any differences relative to Sarah being a Medicare beneficiary versus Sarah being under private insurance.
  - Freestanding Clinic
    - Physician Present, But Doesn’t See Sarah
    - Physician Not Present, Nursing Service Only
  - Provider-Based Clinic
    - Physician Present, But Doesn’t See Sarah
    - Physician Not Present, Nursing Service Only

Final Examination Case Study #1 – Observation Over Three Dates of Service

- An elderly patient presents through the ED where an IV is started, KVO. Attending physician arrives and places patient in observation.
  - Day 1 – Drug A – Infused Over 3 Hours + IV Injection of Drug B
  - Day 2 – Again, Drug A Infused Over 3 Hours + SQ Injection of Drug C
  - Day 3 – Again, Drug A Infused Over 3 Hours + Drug D Infused Concurrently with Drug A

- Patient is discharged home.
  - Discuss how this case should be coded.
  - How will nursing staff accomplish this coding?
Auditing Injections & Infusions
Case Studies

- Final Examination Case Study #2 – Injections and Infusion Audit at the Apex Medical Center
  - You have been retained to conduct a focused audit concerning injections and infusions at the Apex Medical Center. Apex is now a 150 bed facility with a full range of outpatient services. This audit should address the service areas in which injections and infusions are routinely provided. The audit should include: the ED, Observation Services, ambulatory care unit, infusion center, outpatient surgery, pain management clinic and other primary care provider-based clinics.
    - Outline how you would set up such an audit.
    - What kinds of questions will you have?
    - How are you going to select cases for review?
    - How many cases will you want to review for each service area?
    - Do you think you will find current coding/billing policies and procedures in this area?
    - What about physician orders?

Auditing Injections & Infusions
Summary & Conclusions

- Injections, Hydration and Infusions Can Be Complex and Confusing
- Starting in CY2006, CPT Introduced a New Set of CPT Codes
  - New Logic – “Initial/Primary” vs. “Subsequent/Secondary” plus “Concurrent”
  - Coding Can Only Be Accomplished After the Encounter (Case) is Completed
  - Correct Coding Is Difficult – Many Different Circumstances
    - See CPT Hierarchical Approach To Make Decisions
- New Codes Adopted for APCs in CY2007
- Additional Codes Added for CY2008
- Infusion and Injection Renumbering of Codes for CY2009
- Finally, Guideline Changes and Clarifications for CY2010-CY2013
- Hospital Guidance → Use Hierarchical Approach Instead of Initial/Subsequent Logic (Eventually placed in CPT guidance.)
- Chargemaster Issues
  - Static Coding versus Dynamic Coding
  - Charge Development
- Compliance Issues
  - Documentation and Nursing Notes
  - Surgery Related Injections/Infusions + Observation Injections/Infusions
- Financial Implications – Variations in APC Payments